Courtesy Fred DeGregorio

A BRIDGE TO BETTER HEALTH

ANNUAL REPORT 2014

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

Dr. Gregory Steinmetz of Associates in Primary Care in Warwick, R.I. is shown meeting with a patient. Photo Courtesy of Associates in Primary Care.

"Through the innovative work of this collaborative, our state is significantly increasing Rhode Islanders' access to high-quality primary care. Not only is CTC reshaping our state's primary care infrastructure, but they're redefining the way we can all play a role in the success of our health care system."

- Neil Steinberg, President and CEO, Rhode Island Foundation

RHODE ISLAND FOUNDATION

JOIN US AS WE REFLECT ON 2014

Thank you for taking the time to look back on our accomplishments. 2014 was an incredible year filled with growth, transformation and measurable progress that we are eager to share with our many partners, supporters and greater community.

First, we took a bold step and transitioned our state-grown initiative, known as the Rhode Island Chronic Care Sustainability Initiative, to a formally incorporated non-profit organization, now the Care Transformation Collaborative of Rhode Island (CTC). We are governed by a new Board of Directors, with a mission focused on leading the transformation of primary care in an integrated health care system, while improving the quality, affordability and patient experience of care, as well as the health of the populations we serve.

Over the past year, we incorporated new strategies to better meet patient needs, improve patient health and control costs. Programs we launched throughout different parts of the state, including our pilot Community Health Teams and work to integrate behavioral health, target many of our most high-risk and high-need patients and are indeed making an impact. But our work didn't stop there.

We proudly expanded our Collaborative to include an additional 25 primary care practice sites. With our practices now serving more than 300,000 Rhode Islanders, we are well on our way to our long-term goal of siginificantly increasing statewide access to patient-centered medical homes.

We are focused on implementing, evaluating and spreading effective models of care - that includes finding the best ways to pay for it, sustain it and make health care outcomes accountable. Oftentimes, these models are discovered through collaboration. Through our innovative workshops and learning opportunities, we've continued to discover and share new ways to improve and sustain the primary care we deliver every day. In this report, we share some exciting work done in 2014 to do just that.

We are pleased to also share the collective successes of our practices that have demonstrated new progress in improving population health, work to reduce inpatient hospital admissions, and other successful initiatives.

Looking forward, we will build on our work over the last year to set new goals and address challenges to better meet the care needs of our state. From improving costs and efficiency through a new strategic approach to contracting to collaborating with local higher education institutions, we certainly have an exciting year ahead.

We thank everyone who has played an important role in our development and success, and look forward to working with you as we continue to improve health in Rhode Island through practice transformation.

Thomas A. Bledsoe, MD, FACP
President,
CTC Board of Directors

Deidre Gifford, MD,
Co-Chair,
CTC Board of Directors

Kathleen C. Hittner, MD
Co-Chair,
CTC Board of Directors

Debra Hurwitz, MBA, BSN, RN
Co-Director, CTC

Peter ("Pano") M. Yeracaris, MD, MPH
Co-Director, CTC

Who We Are

Care Transformation Collaborative of Rhode Island

At the end of 2014, the Rhode Island Chronic Care Sustainability Initiative proudly announced that we would be changing our name to the Care Transformation Collaborative of Rhode Island (CTC). This change was made to reflect our commitment to transforming the broader delivery of healthcare throughout our state, reaching levels beyond adult primary care. As our Collaborative continues to evolve, our new name highlights our outreach and social support to high-risk patients, the integration of behavioral health, partnerships to support learning curriculums and workforce development and expansion to pediatric care and much more.

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

About Our Patient-Centered Medical Homes

A patient-centered medical home (PCMH) is a model of primary care that is patient-centered and delivers team-based, comprehensive care. Care teams, which support patient care needs, may include medical providers, behavioral health staff, nurse care managers, medical assistants, specialists, home care agencies, hospitals and others. The team, together with the patient and family, identify the needs and work together to improve health outcomes.

PCMH transformation activities are supported through the utilization of electronic health records, patient portals and improved communication and coordination tactics. Further, PMCHs offer extended office hours, same-day appointment scheduling and other strategies that support patient-centric care.

Rhode Island, through the implementation of our Collaborative's strategic vision, is a national leader in the patient-centered medical home movement.

Our Mission

To lead the transformation of primary care in Rhode Island in the context of an integrated health care system; and to improve the quality of care, the patient experience of care, the affordability of care, and the health of the populations we serve.

Our Vision

Rhode Islanders enjoy excellent health and quality of life. They are active participants in an affordable, integrated healthcare system that promotes wellness and delivers high quality comprehensive primary care.

Participating Practices Across Rhode Island

73 practice sites and 433 providers serving more than 300,000 Rhode Islanders

Barrington
Barrington Family Medicine
Medical Associates of RI
Primary Care of Barrington

Bristol
Medical Associates of RI

Burrillville
WellOne Primary Medical and Dental Care

Charlestown
Stuart Demirs, MD

Coventry
Comprehensive Community Action Program
Coventry Primary Care Associates
Duane Golomb and Associates/Brookside Family Medicine

Cranston
Charter Care Medical Associates
Comprehensive Community Action Program
Family Health and Sports Medicine

East Greenwich
Richard Del Sesto
South County Hospital Family Medicine
University Family Medicine

East Providence
East Bay Community Action Program
Medical Associates of RI

Foster
WellOne Primary Medical and Dental Care

Hopkinton
Wood River Health Services

Johnston
Ocean State Medical
Tri-Town Community Action Program

Lincoln
Anchor Medical Associates

Middletown
Family Medical Middletown
Family MediCenter

Narragansett
Coastal Medical
Kristine Cunniff, MD
South County Walk-In and Primary Care

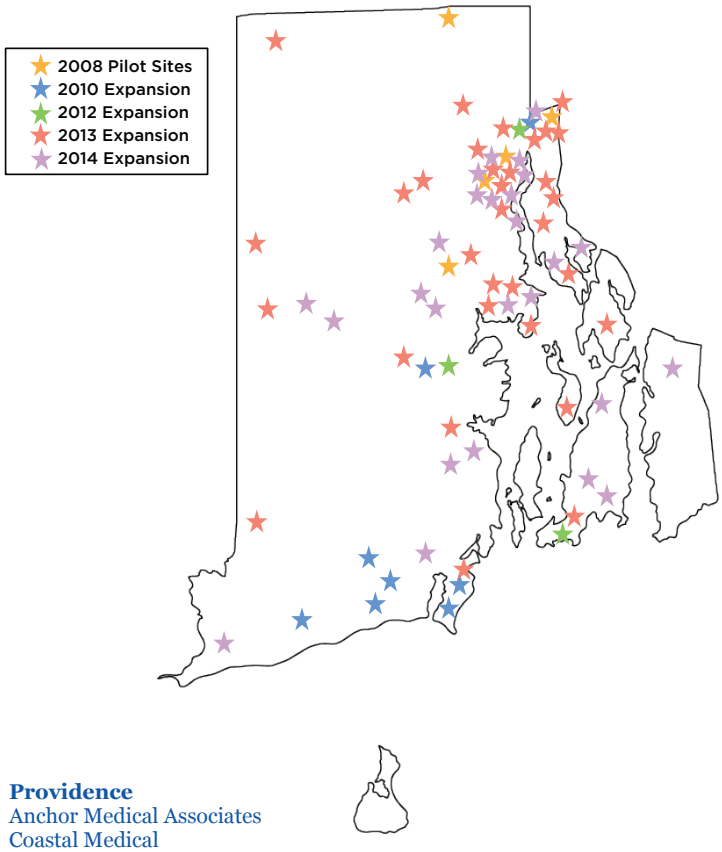
Newport
Aquidneck Medical Associates member of University Medicine
East Bay Community Action Program

North Providence
Internal Medicine Partners

North Kingstown
WellOne Primary Medical and Dental Care
North Kingstown Family Practice
Wickford Family Medicine

Pawtucket
Blackstone Valley Community Health Center
Coastal Medical
Family Medicine at Women's Care
Internal Medicine Center
Memorial Hospital Family Care Center
Nardone Medical Associates
University Internal Medicine
Solmaz Behtash, DO
University Medicine

Portsmouth
Aquidneck Medical Associates member of University Medicine
Linden Tree Family Health Center



Providence
Anchor Medical Associates
Coastal Medical
University Medicine – Governor Street
University Medicine – North Main Street
University Medicine – Plain Street
Women's Primary Care, Women's Medicine Collaborative
Providence Community Health Centers – Capital Hill
Providence Community Health Centers – Central
Providence Community Health Centers – Chad Brown
Providence Community Health Centers – Chafee
Providence Community Health Centers – Crossroads
Providence Community Health Centers – North Main St.
Providence Community Health Centers – Olneyville
Providence Community Health Centers – Prairie Ave.

South Kingstown
Coastal Medical
South County Internal Medicine
Thundermist Health Center
South County Hospital Primary Care Family & Internal Medicine – Wakefield

Tiverton
Tiverton Family Practice

Warwick
Anchor Medical Associates
Associates in Primary Care
Comprehensive Community Action Program
Dr. John Chaffey
Primary Medical Group of Warwick
University Medicine

West Warwick
Arcand Family Medicine
Thundermist Health Center

Westerly
Primary Care Westerly

Woonsocket
Thundermist Health Center

Meeting Our 2014 Strategic Priorities

Our strategic priorities for 2014 included:

- Governance structure planning and implementation
- Focus on high risk patients, including:
  - Establish Community Health Team pilot
  - Expand integrated behavioral health in patient-centered medical homes
  - Improve communication with health plan nurse care managers
- Strengthen communication with hospitals
- Strengthen Developmental Contract
- Expansion
- Program evaluation

Throughout this report, we share some exciting steps the Care Transformation Collaborative of Rhode Island took in 2014 to meet these strategic priorities, including:

Governance Restructuring
We incorporated as an official non-profit 501c3 organization, now called the Care Transformation Collaborative of Rhode Island.

Practice Performance Progress
Our most experienced practices reported a 7.2% reduction in hospital admissions. Further, our practices reported higher patient experiences compared to other Medicare Advanced Primary Care Program (MAPCP) states, improvement in clinical outcomes as practices progress through transformation stages, and we officially rolled out our Community Health Team pilots.

Professional Development
We hosted a successful Large Learning Collaborative, featuring national and local speakers from our practices, with nearly 300 attendees.

Patient Engagement
We hosted a large patient focus group to further engage and evaluate patient experiences in our participating practices.

Expansion
CTC expanded to add an additional 25 practices sites and now proudly serve more than 300,000 Rhode Islanders.

Developmental Contract Reform
We revised our developmental contract with practices to include a greater focus on high-risk patients and practice accountability.

Nurse Care Manager (NCM) Measurement
We began new NCM measurement and reporting processes for high-risk patients.

Practice Facilitation
We expanded practice facilitation services, which will add additional levels of support for our practices.

MAPCP Extension
Our Rhode Island federal grant with CMS for the Medicare Advanced Primary Care Program (MAPCP), the multi-state, multi-payer reform initiative, was successfully extended through 2016.

Active Participation in SIM Development
CTC and our patient-centered model of care played an important role in the state's application for a $20 million State Innovation Model (SIM) initiative.

Additional support for CHTs and IBH
CTC received additional funding from UnitedHealthcare and Tufts Health Plan to support the work of our Community Health Teams and Integrated Behavioral Health efforts to meet the needs of complex patients.

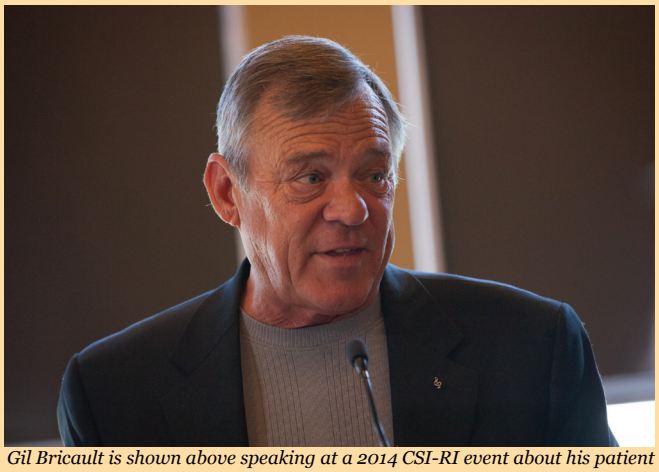
Policy Recommendations
As a leader in the state's primary care reform effort, CTC submitted official comments and recommendations regarding both state and federal policy in 2014.

Patients at the Center of Our Work

As the Care Transformation Collaborative (CTC) continues to progress, the role of patients has become more important in the overall strategy and development of our Collaborative and at the practice level. In 2014, CTC began conversations with patients that have expressed interest in helping form a Patient Advisory Group (PAG). With the goal of improving overall care quality and patient experiences, the PAG will provide an avenue for listening to diverse patient voices, then finding key strategies for incorporating their perspective into the practice setting.

Patient Advisory Groups have also started forming at the individual practice level. Women's Medical Collaborative, a CTC practice in Providence, recently launched a Patient Advisory Council within its primary care practice. This council has resulted in increased understanding, support and respect among patients, families and staff, increased satisfaction for all stakeholders and improved patient education. With CTC's encouragement to continuously innovate and share best practices, Women's Medical Collaborative has shared its resources with other CTC practices interested in launching their own patient council.

In addition to preliminary PAG conversations, CTC hosted a focus group to reach beyond the quantitative data received from patient surveys and hear directly from patients about their primary care experiences regarding levels of access to care, communication between patients and their primary care offices, how patient's health care decisions are made, and how care is managed by both patients and their primary care doctors. The session included a two hour discussion that provided insight on what patients think about their care and what patients would like to see happen as their practices continue to evolve as patient-centered medical homes. CTC has begun utilizing this information to further engage patients and provide practices with ideas on how to hold practice-level patient focus groups.



Gil Bricault is shown above speaking at a 2014 CSI-RI event about his patient experience. Photo courtesy of the Rhode Island Foundation.

Meet Gil, a Patient at Wood River Health Services

"It is one thing to have good primary care health services, it is another thing to have patients know how to use the services to their benefit," said Gil Bricault, a patient at Wood River Health Services, a CTC patient-centered medical home practice in Hopkinton.

During the summer of 2014, Gil found himself utilizing the enhanced patient services offered at his practice, saving him valuable time and money.

Gil was enjoying a relaxing day fishing alone on a lake when he cut his hand on an old knife in his tackle box. After he quickly worked to stop the bleeding, Gil realized he might need a tetanus shot considering the old knife broke his skin. Knowing the emergency room can be costly and time-consuming, he decided to call Wood River Health Services.

When Gil called his practice he was transferred to a nurse who asked a few simple questions about his injury and was able to quickly access and examine his medical records. Much to Gil's surprise, there was no need for him to get a tetanus shot because the nurse saw that he had gotten one a few years prior. She advised him to clean the wound, call back if he showed any sign of infection and to enjoy the rest of his day fishing.

For Gil, this experience reconfirmed the importance of taking advantage of the services offered to him by Wood River Health Services, and ways practices can help patients avoid unnecessary emergency room visits. Gil's quick access to care information during extended hours is just one example of the many ways CTC patient-centered medical homes, like Wood River Health Services, are supporting the unique health needs of more than 300,000 Rhode Islanders.

Innovation and Sharing Best Practices

Our Collaborative thrives when we all come together. Innovation and sharing best practices are key aspects for the PCMH structure. Programs like CTC's Partnering in Best Practice Program allows practices to create innovative programs that support both their staff and their patients.

As part of the CTC Partnering in Best Practice Program, each practice site is eligible to apply for up to $500 to use towards a practice transformation effort. Practices can use the funds to build capacity, improve performance in one of the CTC Contract target areas, and/or provide mentoring support for another CTC practice. One of our practices, Coastal Hillside Family Medicine, did just that.

The Partnering in Best Practice Program funded a four hour workshop-style retreat at Coastal Hillside Family Medicine aimed at improving the patient experience. The retreat allowed the practice staff and primary care providers to review existing practices and protocols to learn how to cultivate a patient ambassador approach in the workplace, and recognize small and large successes on a consistent basis.

Creative Home Visiting Program Supports High-Risk Patients

Our practices often create and share unique programs that enhance each individual practice and increase access to care for patients. In 2013, East Bay Community Action Program established an innovative home visiting program allowing nurse care managers to visit identified high-risk patients in their homes. By visiting patients in their own environments, nurse care managers are better able to assess and meet the needs of patients. For example, nurse care managers may discover financial, environmental or social challenges during home visits that negatively impact how patients are able to meet their health care goals.

Carol Falcone, MSN, RN, Kevin Lagor, BSN, and Marilyn Saunders, BSN.
Photo courtesy of Carol Falcone, MSN.

During each home visit, a nurse care manager takes a physical and mental health assessment of the patient and a safety assessment of their home. The nurse will make changes to the patient's care plan and make safety recommendations if needed.

In 2014 the visiting program hired three additional nurse care managers and one pain care manager who specifically works with patients on pain management and helps patients reduce their pain medication. While data about the effects of this program are not available yet, the home visiting team has indeed seen improvements in patient health and safety. Moving forward, the team is working to get patients more involved with self-management programs that the Health Department offers and work internally to create diabetic health and nutrition education programs.

Large Learning Collaborative Boosts Sharing of Best Practices

During Primary Care Week in October 2014, CTC hosted a successful annual Large Learning Collaborative, "The Primary Care Team: The Future is Now." Nearly 300 doctors, nurse practitioners, nurse care managers, physician assistants, behavioral health clinicians, primary care team members and healthcare community members attended the event to collaborate, learn and share best practices.

The conference featured interdisciplinary national, regional and local speakers who offered state of the art strategies for increasing patient engagement, providing team-based care, meeting the needs of complex patients and integrating behavioral health into the primary care setting. This event, among many efforts lead by CTC throughout the year, help ensure that primary care in Rhode Island continues down the path of becoming more patient-centered, coordinated, efficient and accessible.

CTC is grateful to the Collaborative's planning committee, as well as the many organizations that sponsored the Learning Collaborative, including: The Rhode Island Foundation (RIF), Rhode Island Department of Health, Department of Family Medicine, MHRI/CNE and Brown University, The RIGHA Foundation at RIF, the New England States Consortium Systems Organization as well as the multi-payers who provide financial support for CTC (Blue Cross and Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, UnitedHealthcare and Tufts Health Plan).

Attendees are shown above at the New Practice Orientation. Photo by Richard Asinof / ConvergenceRI, December 2014.

"Opportunities for our experts to come together to learn and share best practices is critical to the success of our Collaborative. We are moving beyond the walls of traditional primary care and introducing new strategies to reform our state's health care system. Learning opportunities, like our Orientation and Large Learning Collaborative, are a fundamental components of our work to discover new, innovative approaches to care."

- Thomas A. Bledsoe, MD, FACP, University Medicine, Governor St. Primary Care Center and President, CTC Board of Directors

Orientation Introduces New Practices to CTC

In December 2014, we proudly welcomed 25 new practices sites to our Care Transformation Collaborative at our New Practice Orientation. Representatives from each practice, in addition to new care team members from our existing practices, came together to learn more about CTC.

Attendees were introduced to the CTC management team and key stakeholders, and received an overview of the CTC developmental contract, reporting requirements, committees and available resources.

Events like our New Practice Orientation serve as valuable learning opportunities for our Collaborative to continue to build relationships, work together and succeed.

Practice Transformation and Excellence

Practice Facilitation Program Supports Practice Success

The CTC Practice Facilitation Program progressed in 2014. Launched the previous year, the Facilitation Program was implemented to pay for and deliver on-site practice facilitation services to CTC practices. In partnership with Blue Cross and Blue Shield of Rhode Island and Brown University Practice Transformation Programs, facilitators spend time at practice sites to help practices define goals and action plans for transformation, achieve performance requirements, meet deliverable deadlines and more. The Practice Facilitation Program continues to serve as an important resource to transform our practices into high-quality patient-centered medical homes.

Practice Facilitation at University Medicine Enhances Customer Service

University Medicine values their team and realizes that the entire care team plays a critical role in the success of patient-centered medical home practice transformation. Practice Managers Sue Rea from University Medicine Warwick and Kathy Arif from University Medicine Barrington, consulted with CTC Practice facilitators Aimee Schayer and Jacqueline Lefebvre on conducting team-building activities that focused on delivering great customer service. Following the team building session, the practice received positive feedback, including remarks such as, "Patients haven't changed, however staff have the tools to be better prepared to communicate with patients, resulting in less patient conflicts."

CTC Practices Achieve NCQA Patient-Centered Medical Home Recognition

The National Committee for Quality Assurance (NCQA) sets specific standards for primary care practices to use in organizing care around patients, working in teams and coordinating and tracking care over time. These criteria provide practices with an actionable guide to creating successful patient-centered medical homes. A core requirement of CTC practices is to achieve NCQA patient-centered medical home recognition.

95% of CTC practice sites have achieved NCQA Patient-Centered Medical Home status, 47 practices are at Level 3 and one practice site is at Level 2.

Further, helping our state build more capacity for practice transformation, 13 care professionals have successfully achieved NCQA Patient-Centered Medical Home Content Expert status. Content Experts are required to complete two NCQA educational seminars, pass a comprehensive exam and commit to continuous learning and re-certification to maintain the credential. Congratulations to the 13 professionals who achieved this content expert status.

NCQA Content Experts

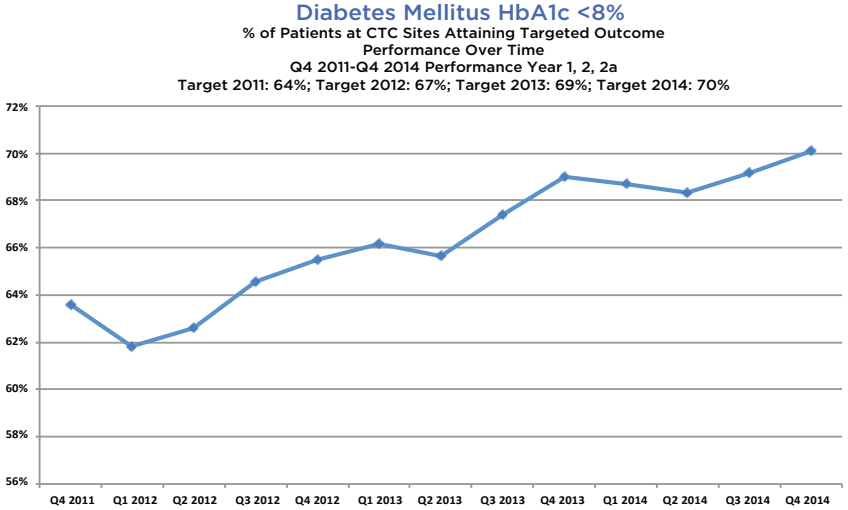
- Victoria Adewale, MSc, Brown Practice Facilitation Team
- Jacqueline Bessette Lefebvre, RN, CPEHR, PCMH Practice Facilitator, Blue Cross and Blue Shield of Rhode Island
- Joanna Brown, MPH, Practice Transformation Director, Brown Primary Care
- Susanne Campbell, RN, MS, Senior Project Director, CTC Management Staff
- Lauren Capizzo, BA, MBA, CPEHR, Senior Manager of IT and Practice Improvement, Healthcentric Advisors
- Kerri Costa MBA, Manager Regional Extension Center (REC), Rhode Island Quality Institute
- Sue Dettling, Senior Associate Relationship Manager, Rhode Island Quality Institute
- Chris Grey, PCMH-CCE, COO, Blackstone Valley Community Health Center
- Suzanne Herzberg, PhD, MS, OTR/L Brown Practice Facilitator Supervisor
- Mary Hickey, BS, RN, CCM, Population Health Program Manager, Lifespan
- Brenda Jenkins, RN, CPEHR, CDOE Senior Program Administrator, Healthcentric Advisors
- Andrea Levesque, PMP, Relationship Manager, Rhode Island Quality Institute
- Aimee Schayer, RN, BSN, CPEHR, Practice Facilitator, Blue Cross and Blue Shield of Rhode Island

2014 Highlights by the Numbers

Improving Population Health of Patients with Diabetes

Diabetes occurs when the body cannot produce or respond appropriately to insulin, a hormone the body needs to absorb and use glucose (sugar). Without a properly functioning insulin system, blood glucose levels become elevated, leading to the development of serious, disabling complications.

Our practices report on quality measures every quarter with the goal of improving performance over time. Of particular importance is how practices are performing on assisting patients with diabetes with managing their disease. This measure ("diabetes HbA1c less than 8%") looks at the percentage of patients with diabetes (Type 1 or 2) age 18-75 with controlled blood sugar.



Nurse care managers (NCM) are embedded in every CTC practice, and over 20 NCMs are Certified Diabetes Outpatient Educators (CDOEs). They work to understand the patient's point of view, barriers to managing diabetes and what might be helpful for the patient in managing medications, diet and exercise.

What difference does this make in the lives of our patients? According to the Center for Disease Control, reducing A1c (the measure of blood glucose control) by just 1% can reduce the risk of eye, kidney and nerve disease by 40%.

CTC practices have demonstrated consistent improvement over time in improving population health.

How does CTC performance compare with other patient populations on a national level? The National Committee for Quality Assurance (NCQA) publishes data on performance looking at insured patients by health plan. According to the 2014 "State of Health Care Quality Report," patients with good diabetes control range from a low of 45.5% (Medicaid HMO) to a high of 65.6% (Medicare HMO). Our performance of 70.1% exceeds the high end of the national benchmarks by 4.5%

Karen Sciamacco Named 2014 Certified Diabetes Outpatient Educator of the Year

Karen Sciamacco, RN, BS, CCM, CDOE, nurse care manager at Associates in Primary Care Medicine, was named the 2014 Certified Diabetes Outpatient Educator of the year. Karen's work has resulted in significant patient health care improvements for her patients.

Karen Sciamacco, RN, BS, CCM, CDOE

Karen recently shared a success story of one patient, a 44-year-old with unique learning needs, who was diagnosed with type two diabetes and had a HbA1c of 10.6. Karen and her team worked together with the patient and the patient's mother to provide diabetes education, a unique care plan, and worked with the patient's insurance to obtain a glucometer and insulin pen. The patient was not testing blood sugar levels to avoid a finger prick, so Karen worked with the patient and family to create a plan to address this.

Thanks to the work of Karen and her team, the patient began learning how to self-manage the chronic condition, and accept help from family. The patient now has regular visits with their primary care physician, meets with Karen every 1-2 weeks, and attends a diabetes group at Associates in Primary Care for continued support. The patient recently reported a four point HbA1c decrease.

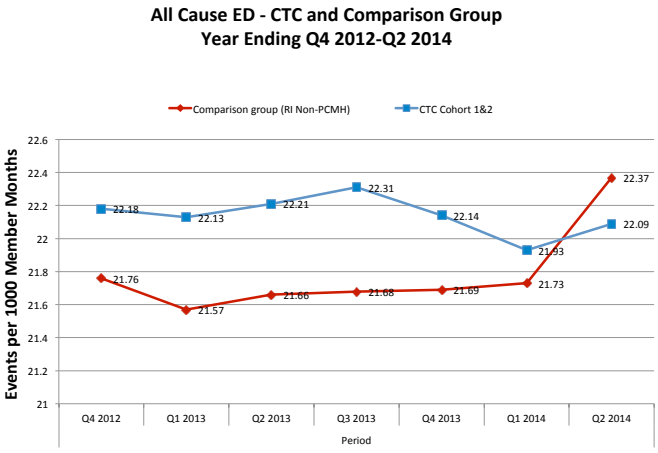
The key to success is understanding the patient and family needs and strengths. According to Karen, "Each patient has a unique set of circumstances and barriers that I work with and find solutions for."

Karen is one of more than 20 nurse care managers in CTC (and 335 in Rhode Island) who are Certified Diabetes Outpatient Educators and work every day to help improve the quality of life for many Rhode Islanders.

2014 Highlights by the Numbers

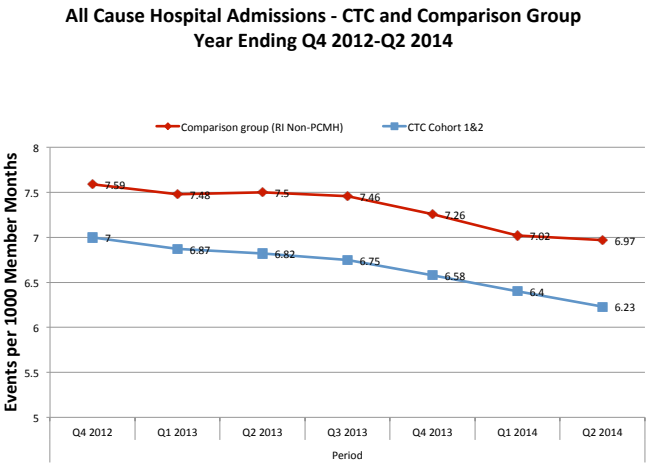
All Cause Emergency Department Visits

CTC practices have traditionally experienced higher emergency department (ED) visit rates than the comparison group, this in part is due to the proportion of Medicaid patients in CTC practices. Over time, ED visits have been trending down, and in the last quarter CTC practice ED visits rates dropped below the comparison group. Practices have focused on patient education; increased office hours and outreach to high-risk patients as ways to reduce preventable ED visits.



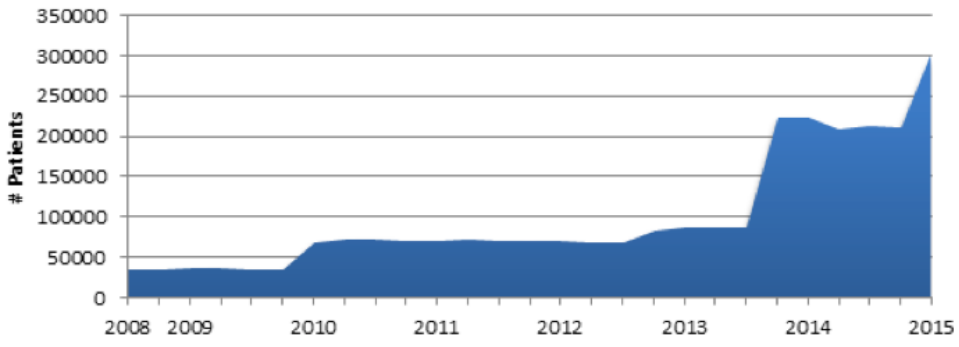
All Cause Hospital Admissions

CTC practices continue to show fewer in-patient admissions than the comparison group with a steady downward trend. Over a two year period, CTC practices have demonstrated an 11% decrease compared to an 8.1% decrease in the comparison group.



Increasing Access to Patient-Centered Medical Homes

Patients Attributed to CTC

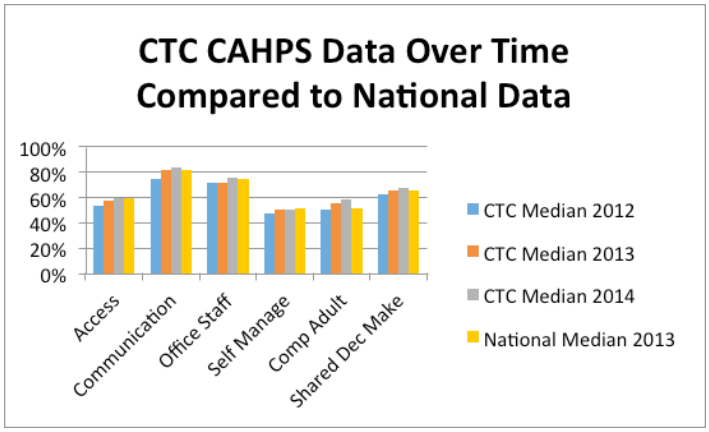


Since 2008, CTC has grown to include 73 practice sites, with 430 providers caring for more than 300,000 Rhode Islanders. Our growth reflects the shared commitment from providers across the state to improving population health, the experience of care and its associated costs.

2014 Highlights by the Numbers

Improving the Patient Experience

The CAHPS Survey is a standardized survey used by primary care practices to ask patients about their experiences with care.



CTC utilizes this customer service data to drive improvement, and our practices obtain incentive payment based on their performance in access, provider communication and office staff communication areas.

In 2013, nationwide there were 1,234 practices that asked 428,754 adult patients about their patient experiences. Compared to national averages, CTC practices exceeded national scores in areas of provider communication, office staff communication, comprehensive adult care, and shared decision making, and performed at-level with national data on access to care. Further, CTC practices have consistently demonstrated improvement over time in customer experience as they continue to use data and action plans to drive improvement.

Improving Customer Service and Patient Satisfaction

To improve customer service at their practice, Thundermist Health Center created a centralized call center to handle incoming calls to all three of their locations. The call center schedules appointments, takes messages and provides answers to patients who have questions about their health care and Thundermist's services. With a goal of answering 80% of calls in under 60 seconds, the call center team works together with clinical staff to provide first call resolution. Along with resolving caller issues, the call center also educates patients about Thundermist Health Center so that patients have a better understanding of how the practice works and how to best address their concerns.

In 2015, Thundermist Health Center will be opening a new facility at their Wakefield location which will increase patient volume. The call center is looking into expanding its services to include answering calls that come into Thundermist dental offices, allowing dental receptionists on site the ability to focus on face to face interactions with patients. The Call Center is also exploring new software that will provide real time data and improved reporting.

As the Thundermist Call Center continues to evolve and improve they have made themselves available to help other primary care offices start their own call centers by sharing their best practices at CTC leadership meetings.

Thundermist Call Center employees are shown above. Photo courtesy of Thundermist Health Center.

Addressing the Complex Care Needs of Patients

Launch of Community Health Teams

With many practices lacking the resources to fully meet the needs of patients with multiple medical and social needs, or mental health and addiction service needs, CTC rolled out two Community Health Team pilot programs in 2014 to address these challenges. The pilot programs, located in South County and Pawtucket, better enable participating practices to assist high-risk/high-cost patients with meeting their health care needs. With funding provided by the health insurance plans, these pilots have begun to make an impact in their communities.

South County Community Health Team

The South County Community Health Team (CHT) pilot supports Coastal Narragansett, Coastal Wakefield, Dr. Cunniff, Dr. DelSesto, Dr. Demirs, South County Internal Medicine, South County Medical Group, East Greenwich, South County Walk-In and Primary Care, Thundermist Wakefield and Wood River Health Services. The CHT consists of a manager, analyst, community resource specialists and a behavioral health care manager.

The South County practices began introducing the program to patients in the summer of 2014, followed by waves of outreach by the team to the targeted patients, including home visits, and engagement at practices, in the community and over the phone. The team, focused on more than 200 referred patients, starts by identifying the social and behavioral health needs that can affect patient health or present barriers to care. They evaluate the person's home environment and bring valuable information back to the primary care teams. Further, they provide care coordination, collaborating, whenever possible, with other local agencies that are offering services that are available but not known to the patient.

The CHT reports successful collaboration with nurse care managers and primary care physicians, including warm patient hand-offs and ongoing care discussions, among other high-risk patient successes. The CHT is working with the practices to address challenges determining cost drivers and reasons for high-risk/high-cost to focus interventions on the areas of patient impactability. The CHT has developed a patient registry for data capturing and reporting, and is focused on developing behavioral health compacts with local agencies, expanding outreach to the target population, improving transportation options and more.

Blackstone Community Health Team

Based in Pawtucket, the Blackstone Community Health Team (CHT) includes Blackstone Valley Community Health Center, Memorial Hospital of Rhode Island Family Care Center and Hillside Family Medicine. Together, the CHT, consisting of community resource specialists, coordinator, manager and behavioral health nurse care manager, is focused on supporting patients identified by insurers as high-risk for future hospitalization and ER use. The CHT works with nurse care managers at participating practices to identify and address social needs that affect patient health and barriers to care, provide support for care management plans, provide patients with social support to manage their health and bring relevant information back to primary care teams.

Outreaching to more than 400 patients, in 2014, the Blackstone pilot program found success actively engaging patients and establishing relationships, communicating with practices, enhancing nurse care management activities, identifying and resolving social needs and barriers to care. The pilot program is working to address challenges experienced, such as barriers to electronic communication between the CHT and primary care practices and insufficient community resources.

Moving forward, the Blackstone CHT will develop and implement CHT Behavioral Health Interventions, engage community partners to establish a Pawtucket/Central Falls Community Health Council, explore potential pharmacy and dietary interventions, and expand to other CTC practices in Pawtucket.

Advancing Integrated Behavioral Health within Primary Care

The Integrated Behavioral Health (IBH) Committee, established in 2013 with representatives from the health plans, practices, state agencies and behavioral health providers, made steady progress throughout 2014. The Committee conducted an environmental scan on the behavioral health services available in Rhode Island, including their location, eligibility criteria and how to make referrals; conducted a survey of primary care providers to identify the barriers to integrated behavioral health and obtaining feedback on provider needs in delivering integrated care; and obtained funding from Tufts Health Plan to support on-site clinical training provided by Dr. Nelly Burdette, a clinical psychologist and subject matter expert.

In 2015, the IBH Committee will work toward full implementation of the IBH practice training program inclusive of quarterly webinars for all practices on topics identified by the primary care practices. Further, the Committee will advance a web-based referral system and patient engagement tools for supporting positive behavior change, in addition to developing a board proposal outlining a sustainable clinical and financial model to support INH within the patient-centered medical home model.

Collaborating to Improve Health in Rhode Island

Partnering with Rhode Island College to Develop New Graduate Certificate Program

Following a CTC assessment of the learning needs of our many nurse care managers (NCMs) in late 2013, nursing faculty members from Rhode Island College (RIC) developed a program to help meet these needs. With input from CTC leaders, the RIC NCM Graduate Certificate Program was developed and officially approved in spring 2014. Soon after, Masters-prepared adjunct instructors, including CTC nurse care mangers, were recruited as content experts for the new course in nursing care management.

The NCM Graduate Certificate Program at RIC is the first of its kind in Rhode Island, and consists of five courses (15 total credits) taught in the evenings, some using a hybrid course design that blends standard and online learning. The curriculum, based on standards from the American Nurses Association and the Case Management Society of America, includes Nurse Care Management, Healthcare Systems, Professional Role Development, Epidemiology and Public Health Science courses.

In fall 2014, 10 experienced nurses from acute care, home care and patient-centered medical home backgrounds successfully completed the first NCM program class. Many have chosen to continue their nursing education through several avenues at RIC.

Meet Jessica Devine, a Current NCM Certification Student at Rhode Island College

Jessica Devine, RN, BSN, CDOE, is a current nurse care manager at the Division of Kidney Disease and Hypertension at University Medicine. She takes pride in her role and is excited to be part of "nursing of the future."

After years in the field, Jessica wanted to learn more about being an effective nurse care manager (NCM). With plans to pursue an advanced degree, she saw the Rhode Island College (RIC) NCM Certification Program and decided it would be a great entry point.

"It was scary for me to go back to school after many years, but the professors at RIC are invested in this program and are willing to help you overcome any barriers that you may have," said Jessica.

After completing the program's first class, Nurse Care Management, she reports the program has been a very positive experience. Jessica plans to finish the program and sit for the NCM certification exam. She believes the certification will be a reflection of the hard work she's spent educating herself to become a better NCM.

Jessica Devine, RN, BSN, CDOE is shown above in her office at the Division of Kidney Disease and Hypertension at University Medicine.

"I think that it is beneficial for practices to have a NCM because we bring a whole different aspect to a patient's care," said Jessica. "Each person brings an important feature to the care team and my role is to educate, advocate, teach and listen, all the while being a compassionate caregiver."

Through her further education and certification, Jessica believes that she will be able to better serve her patients.

Rhode Island Wins $20 Million State Innovation Model Initiative Grant

In late 2014, Governor Lincoln Chafee and Rhode Island's congressional delegation announced that the U.S. Centers for Medicare and Medicaid Services awarded our state $20 million to fund a State Innovation Model (SIM) initiative. The state has put together an initiative, Healthy Rhode Island, which seeks to chart Rhode Island's course from a volume-based health care system to a value-based health care system. This will be guided by the Triple Aim, striving to improve population health and the care experience at a lower cost.

Noted within the Healthy Rhode Island plan, this initiative will aim to build on our successful multi-payer patient-centered medical home initiative to ensure that every Rhode Islander that would like access to a patient-centered medical home will indeed have access. Further, the state's SIM grant proposal included a funding request for the expansion of patient-centered medical homes in Rhode Island, which includes the expansion of our program to pediatrics, known as PCMH-Kids, expanding Community Health Teams and implementing integrated behavioral health in primary care.

CTC looks forward to contributing to the successful implementation and impacts of the SIM grant, and further growth of patient-centered medical homes in our state.

Collaborating to Improve Health in Rhode Island

PCMH-Kids Progresses in 2014

PCMH-Kids had many exciting developments in 2014 toward initiating a pediatric-specific primary care transformation collaborative, convened by EOHHS and OHIC. Co-chairs Patricia Flanagan, MD, FAAP and Elizabeth Lange, MD, FAAP engaged a group of stakeholders consisting of primary care and behavioral health providers, payers, patient and family representatives, state agencies and community entities to guide the strategic direction of the program. A grant from the Rhode Island Foundation supports PCMH-Kids' first year of initiation and development.

Following an open call for applications, PMCH-Kids received 15 applications representing 20 pediatric and family practice sites and 74,402 patients. A Selection Committee will review the applications to select the initial pilot sites in 2015.

A Contracting Committee consisting of representative providers, major health plans and OHIC has begun negotiations on how to financially support the work of transformation in a pediatric medical home; how to support the care coordination needs of the practice, including how to tier payments based on the complexity of the patient; and how to drive improvement in cost and quality. PMCH-Kids anticipates bringing on board the pilot sites and engaging these providers in further contract negotiations to incorporate several key differences from the CTC Contract, including: pediatric-specific measures; tiered payments based on the medical complexity of the patient; paying for care coordination activities versus a Nurse Care Manager; and paying for the integration of behavioral health.

A Measurement Committee was convened to identify a set of pediatric-specific measures that reflect the goals of the initiative and drive performance improvement, including measures for HPV Vaccination, BMI assessment, child immunization, adolescent immunization, well child care, developmental screening, behavioral health screen, oral health, asthma and transitions to adult care.

The selected practices will also be provided onsite and collaborative practice facilitation services from Healthcentric Advisors to help develop and produce reports from the EHR, support in the NCQA application process and other transformational support.

PCMH-Kids looks forward to contributing to the innovation and data-driven reform of the health care system.

Working in Partnership with Rhode Island Department of Health to Improve Population Health

CTC practices and leadership have long benefited from having shared vision, goals and alignment with The Rhode Island Department of Health (HEALTH) as we look to develop a systematic approach to improving population health. This collaboration has resulted in a stronger infrastructure for staff development and training, patient engagement and self-management support, reducing health care disparities and building community health neighborhoods. Below are ways this partnership has resulted in better care.

Patient Self Care Management Support: **As an example, one of our practices recently made a referral to the Diabetes Prevention Program (DPP) through the Community Network Referral (CNR) system. HEALTH, through funding from the Center for Disease Control (CDC) can offer patients education and support systems for weight reduction. In this case, the patient navigator from the Community Health Network sought to learn from the patient about her functional life style goals and match the patient needs with the community resource. The patient participated in the DPP support group, lost a significant amount of weight and now plans to use a YMCA membership to help her "keep the course."**

Staff Development and Training: **Our nurse care managers recently honored Dona Goldman, RN MPH, Team Lead for Chronic Care and Disease Management at HEALTH, who spearheaded the Diabetes Certified Diabetes Outpatient Educators (CDOE) program in 1980. There are presently 335 CDOE's in our state, with 20 attributed to CTC. Further, HEALTH collaborates with Brown University Office of Continuing Medical Education and other partner agencies to offer a monthly chronic disease webinar series. Topics are selected to assist practices and health care teams with integrating quality improvement and patient activation strategies to assist patients who have chronic illnesses.**

Health Equity Zones (HEZ) and Community Health Neighborhoods: **CDC recently awarded HEALTH approximately $1.7 million to fund 11 RI non-profit organizations and local agencies to support innovative approaches to improving health outcomes. Health Equity Zones (HEZ) which represent defined geographic areas with high rates of obesity, illness, injury, chronic disease or other adverse health outcomes will work to improve health outcomes through coordinated strategies. Our practices will be participating in the HEZ initiatives as they seek to better connect patients with community resources and improve population health within their communities.**

PAGE 18

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Supporting Data Collection and Analysis

The Rhode Island Quality Institute (RIQI) has worked with CTC to implement a dedicated CTC measurement and reporting infrastructure allowing providers to review their performance on benchmarks in comparison to their peers, and to collaborate around best practices. RIQI also supports CTC by coordinating the CAHPS patient survey for each practice site. The survey, conducted using a validated survey designed to measure patient experience in medical homes, provides feedback to practices on several important areas, including access to care, provider communication with patients, friendliness and courteousness of office staff and self-management support. In 2014, RIQI produced the first Progress Report for CTC, detailing for a lay audience the quality, utilization, and patient experience results over the course of the program.

The team of Relationship Managers from RIQI's Regional Extension Center (REC) continues to guide providers toward achieving Meaningful Use of electronic health records (EHR) and to assist with adoption of CurrentCare services.

Boosting CurrentCare Enrollment

The Rhode Island Quality Institute (RIQI) continues to work with CTC to embed technology into daily practice workflow to help achieve the triple aim of health care: improving patient care, improving population health, and reducing cost. All CTC practice sites advise their patients to enroll in CurrentCare, Rhode Island's state-wide health information exchange (HIE) that allows providers to share patient information and coordinate care more effectively. At the end of 2014, there were more than 439,000 individuals enrolled in CurrentCare – 115,000 of these were enrolled by CTC practices.

The CurrentCare Viewer enables all of a patient's providers to easily access an electronic record of care, helping to reduce duplicate tests and support communication between providers. To date, approximately 589 CTC clinical users have access to CurrentCare Viewer. Further, roughly 64 CTC sites have implemented CurrentCare Hospital Alerts which notify providers of a patient's inpatient or emergency department admission and discharge at all of Rhode Island acute care hospitals. These Alerts assist providers by providing timely information for coordination of care, to help reduce hospital readmissions, thereby helping to reduce costs and improve care.

A Year of Investment in Care

Tufts Health Plan Invests in Integrating Behavioral Health

With a commitment to integrated behavioral health and the importance of the patient-centered medical home model of care, Tufts Health Plan has funded three CTC projects designed to test strategies for increasing patient access to behavioral health services within primary care settings. The projects were created based on findings from a survey conducted by CTC to assess behavioral health needs in our practices across the state.

"Research supports that patients will experience better access to mental health services if offered in a primary care setting," said Dr. David Brumley, senior medical director at Tufts Health Plan. "Our hope is that these projects will help strengthen how primary care practices can improve their abilities to respond to patients' needs for behavioral health interventions and address some of the significant issues facing Rhode Island residents, such as substance abuse, depression and anxiety disorders."

The three projects include: implementing education and training to improve the capacity of primary care staff to provide integrated behavioral health services; expanding web-based referrals and care coordination to improve Rhode Island's behavioral health referral network for primary care providers to refer patients for behavioral health specialist or addiction disorder specialist appointments; and accessing technology tools for behavior change to improve patient engagement in making healthier lifestyle choices through interactive website applications.

A Year of Investment in Care

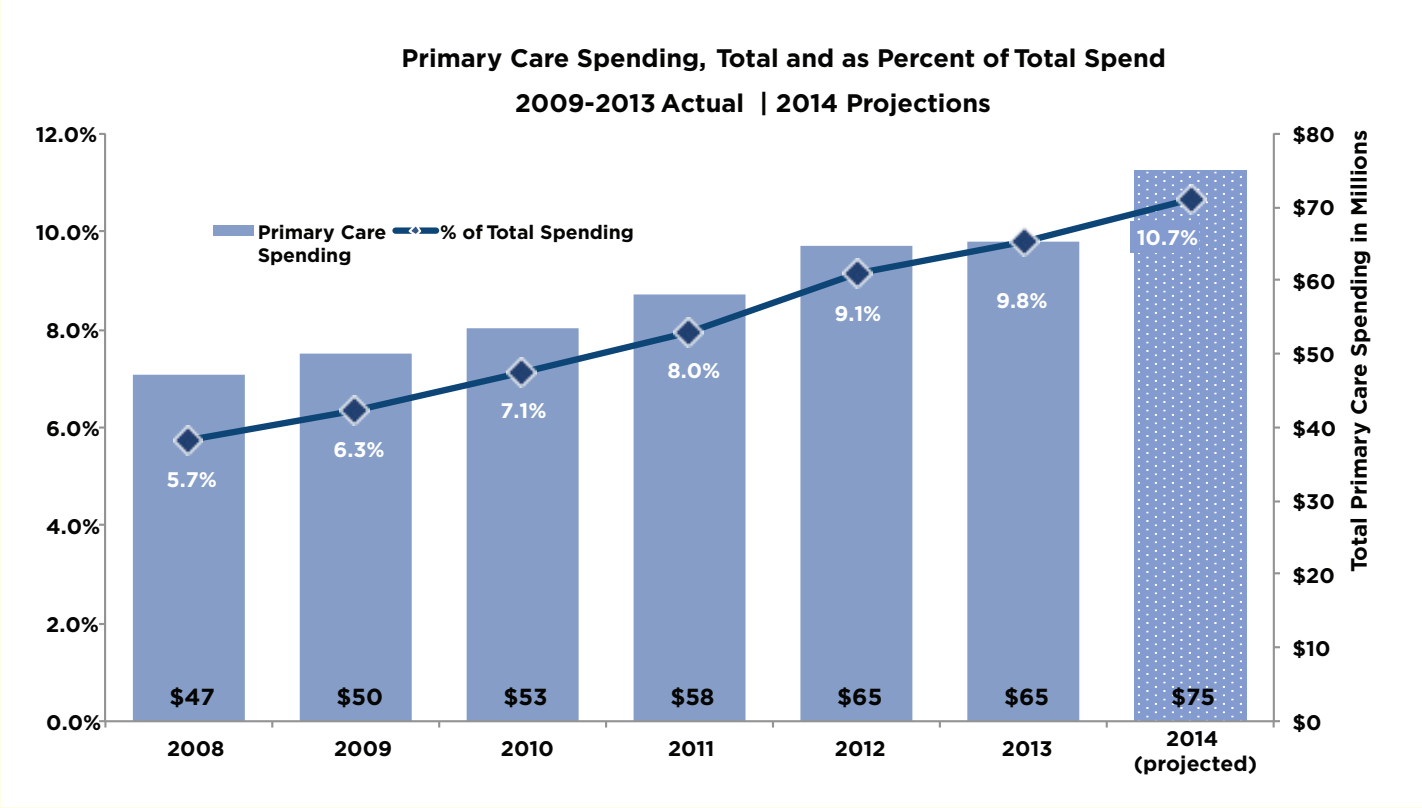
UnitedHealthcare Supports Community Health Teams

In 2014, we launched our Community Health Team pilot program in South County and Pawtucket to address the unique needs of patients with multiple medical and social needs, and mental health and addiction service needs. Medical practices participating in the pilot program received access to much-needed resources to improve care for these high-risk, high-need patients while reducing costs. UnitedHealthcare's leadership and financial support enabled us to hire Community Health Team staff, including multiple community resource specialists for each pilot site, who are critical to the success of this pilot. In addition, UnitedHealthcare provided data to help identify at-risk individuals to help them get to needed services and to track progress in reducing unnecessary emergency room and hospital visits.

Affordability Standards Continue Investment in Primary Care

Following the Office of the Health Insurance Commissioner's (OHIC) launch of our Collaborative and at the advice of its Health Insurance Advisory Council, OHIC directed Rhode Island's major commercial health insurers to comply with a set of four criteria, known as the Affordability Standards, aimed at improving the affordability of healthcare in our state.

OHIC has evaluated the efficacy of these Standards, and found they have increased primary care infrastructure in Rhode Island, accelerated patient-centered medical home transformation efforts, and reduced the rate of hospital cost increases. In 2013 and 2014, OHIC worked with health insurance carriers, its Health Insurance Advisory Council and other stakeholders to revise the Affordability Standards. The revisions aim to move the healthcare delivery system in a direction that will slow the growth of healthcare costs, and also improve the efficiency and quality of the care that is being delivered throughout the state.



Among these changes, OHIC will continue to emphasize the need for strong primary care infrastructure in the state, both through continuing to require health insurance carriers to devote at least 10.7% of their total medical spending to primary care, including direct payments to primary care practices and supports for the development of patient-centered medical homes. Additionally, OHIC has set a new standard around "primary care practice transformation" that requires health insurance carriers to have 80% of their contracted primary care practices operating in a patient-centered medical home by 2019. In order to develop a transformation plan to achieve this 80% goal, OHIC is convening a Care Transformation Committee, composed of a variety of stakeholders, to discuss year over year targets and the supports that primary care providers will need to deliver more integrated care. An Alternative Payment Methodology Committee is also being convened to focus on reducing fee-for-service payments and moving toward alternative payment methodologies (APMs) that provide incentives for better quality and efficient care delivery. This committee is charged with developing annual APM targets and a plan to achieve those targets.

Our Years of Development and Growth

2006
To address four key priorities of the Office of the Health Insurance Commissioner, former Commissioner Christopher Koller proposes the creation of a multi-payer patient-centered medical home initiative. The Center for Health Care Strategies' Regional Quality Improvement Initiative awards a grant to support this work, beginning pilot program discussions.

2007
Primary care providers, hospitals, payers, purchasers and state agencies continue to meet to discuss the opportunity to form a patient-centered medical home initiative pilot program.

2008
The Rhode Island Chronic Care Sustainability Initiative launches with five pilot practices, becoming one of the nation's first multi-payer, public-private patient-centered medical home initiatives.

2009
The Office of the Health Insurance Commissioner announces the creation of the Affordability Standards, which support more primary care spending and patient-centered medical homes.

2010
Rhode Island becomes one of eight states selected to join the Medicare Advanced Primary Care Practice demonstration (MAPCP), run by the Center for Medicare and Medicaid Services.

The Rhode Island Chronic Care Sustainability Initiative expands to add eight new practice sites.

2011
The Rhode Island Chronic Care Sustainability Initiative issues an RFP for project management and retains the University of Massachusetts Medical School, and the Rhode Island Foundation begins providing space and serving as the fiscal intermediary.

2012
The Rhode Island Chronic Care Sustainability Initiative expands to include three additional practices, giving 16,000 additional patients access to a patient-centered medical home, reaching the cap of 10,000 Medicare fee-for-service beneficiaries.

Meredith Rosenthal, Harvard School of Public Health, presents Program Evaluation results of the pilot program's first two years.

2013
The Rhode Island Chronic Care Sustainability Initiative expands to include 20 additional practices, increasing patients-served to more than 220,000 Rhode Islanders.

2014
The Rhode Island Chronic Care Sustainability Initiative transitions from a state-grown initiative to a formally incorporated non-profit organization, now called the Care Transformation Collaborative of Rhode Island (CTC).

25 primary care practice sites are accepted to join CTC, growing CTC to now include 43 primary care practices with 73 total practice sites, providing more than 300,000 Rhode Islanders with access to a patient-centered medical home.

Looking Ahead

Introduction of New "Advanced Collaborative"

CTC has developed an Advanced Collaborative initiative focused on improving participating practices' performance in contracts with responsibility for total cost of care and population health. These advanced practices, working collaboratively with health insurers and other stakeholders, will help chart the course for continued advancement of primary care within payment reform and clinical care transformation activities in Rhode Island.

Advanced Collaborative practices will support and help lead the new CTC Clinical Strategy and Cost Committee, which will also include key health plan, practice and organizational leaders. The Committee will work to identify and implement the best clinical and financial strategies to improve quality and reduce cost, with the expectation that this work will inform changes in curriculum and the developmental contract for current and future CTC practices to support more rapid and effective change. These practices will also work collaboratively with Community Health Teams to support high-risk patients by connecting them to community-based services that address social, financial and behavioral health needs.

Giving More Rhode Islanders Access to a Patient-Centered Medical Home in 2015

Over the years, the growing number of applications received from practices to join CTC tells us that providers are looking for more innovative ways to provide quality care to their patients, and want to participate in a program that moves them toward value-based payment.

Focused on expanding access to patient-centered medical homes, CTC will expand in 2015 to include additional practice sites, including family and pediatric care practices. We look forward to supporting new practices as they transform into high-performing patient-centered medical homes, strengthening our efforts to improve the way primary care is delivered and paid for throughout Rhode Island.

Practices across the state, including health centers and group practices, will be selected based on their track record of working collaboratively with hospitals, specialists and community based services, as well as their demonstrated interest in utilizing Community Health Teams and integrating behavioral health.

Our Future Plans

While we made significant progress in 2014, we are motivated by our mission to lead the transformation of primary care in our state. We will build on our momentum to improve the quality of care, patient experience, affordability of care and health of the populations we serve. 2015 will be an exciting and busy year for us as we focus on the following priorities:

- Improving the cost of care and efficiency, including the new Advance Collaborative and total cost of care focus.
- Expanding to include additional practices.
- Evaluating, refining and scaling our Community Health Teams.
- Continuing our work to integrate behavioral health, to include clinical and financial recommendations and efforts to reduce disparities.
- Integrating PCMH-Kids under the same administrative umbrella as CTC to allow for the benefit of built infrastructure for collecting and analyzing data, as well as the sharing of resources and best practices.
- Expanding our Collaborative's learning curriculum.
- Improving our data analytic capability, including leveraging an all-payer claims database for practices and program evaluation, increasing standardized actionable reports to practices, standardizing reporting to assist with total population management, and ACO analytics and data feeds.
- Enhancing methods to achieve great patient engagement.
- Workforce development, which will include continued collaboration with higher education institutions such as Rhode Island College, Community College of Rhode Island, Johnson & Wales University and Brown University.

Our Leadership

Board of Directors

Responsible for the strategic direction and overall governance of our Collaborative.

Conveners/Co-Chairs
Kathleen C. Hittner, MD, OHIC (co-chair);
Deidre Gifford, MD, EOHHS (co-chair);
Tom Bledsoe, MD, University Medicine (president)

Health Plan Representatives
Erik Helms, MD, Blue Cross and Blue Shield of Rhode Island; Neal Galinko, MD, UnitedHealthcare; Paco Trilla, MD, Neighborhood Health Plan of Rhode Island; David Brumley, MD, Tufts Health Plan

Providers Representatives
Al Puerini, MD; Ken Sperber, MD; David Bourassa, MD; Maureen Claflin, MSN, RN (secretary); Patricia Flanagan, MD; Elizabeth Lange, MD

Standing left to right: Elizabeth Lange, Erik Helms, Deidre Gifford, Howard Dulude, Lou Giancola, Maureen Claflin, Ken Sperber, Al Kurose, Jeff Borkan, Paco Trilla, Tom Bledsoe. Sitting left to right: Al Charbonneau, Al Puerini, Kathleen Hittner

Hospital Representatives (Community Health Teams)
Lou Giancola, South County Hospital; Ed Schottland, Memorial Hospital/Care New England

Employer Representatives
Howard Dulude, Lifespan; Al Charbonneau, Rhode Island Business Group on Health (treasurer)

At Large Representatives
Jeffrey Borkan, MD, PhD, Alpert Medical School, Brown University; Al Kurose, MD, Coastal Medical

Management Team

Responsible for the day to day management of our Collaborative.

Debra Hurwitz, MBA, BSN, RN
Co-Project Director

Pano Yeracaris, MD, MPH
Co-Project Director

Susanne Campbell, RN, MS
Senior Project Director

Michael Mobilio, BS
Project Coordinator

Shannon Massaroco
Project Coordinator

Catherine Sampson, BS
MAPCP Project Manager

Left to right: Debra Hurwitz, Pano Yeracaris, Susanne Campbell, Michael Mobilio, Shannon Massaroco, Catherine Sampson

Our Leadership

Committees and Workgroups

Our committees and workgroups are an integral part of the Care Transformation Collaborative of Rhode Island – they foster collaboration, innovation, the sharing of best practices and strive to discover ways we can continue to reform primary care in our state.

CTC Steering Committee

Provide guidance and insight for strategic direction and long term strategies; monitor and review performance of the Collaborative and provide a learning forum for all Collaborative members.
Chairs: Tom Bledsoe, MD; Deidre Gifford, MD; Kathleen Hittner, MD

CTC Contracting Committee

Responsible for contract development, attribution, and looking at alternate payment models and PCMH as part of a delivery system. Serve as liaison to other committees.
Facilitators: Debra Hurwitz, MBA, BSN, RN; Pano Yeracaris, MD

Community Health Team Planning Committee

Develop a plan for implementation and evaluation of a Community Health Team in South County and Pawtucket.
Chair: Paco Trilla, MD

Data & Evaluation Committee

Lead performance improvement, measure selection and harmonization; develop goals and benchmarks, evaluation, research, and liaison with the APCD. Serve as liaison to other committees.
Chairs: Peter Hollman, MD; Chris Grey, PCMH-CCE; Jay Buechner, PhD

Integrated Behavioral Health Workgroup

Establish a workgroup to lead the transformation of primary care in RI in the context of an integrated health care system
Chairs: Matt Roman, LICSW, MBA; Roanne Osborne, MD MBA

Nurse Care Manager Best Practice Sharing Meeting

Support best practice sharing, workforce development and role of care manager in improving population health and care coordination.
Facilitators: Deb Hurwitz, MBA, BSN, RN; Susanne Campbell, RN, MS

Practice Reporting Committee

Review practice data quarterly, perform data validation, public reporting via CTC web portal, support quarterly performance improvement and data sharing meetings with practice staff, and assist with EMR/IT issues where possible. Serve as liaison to other committees.
Chairs: Kathryn Amalfitano, MPH; Cynthia Souther, MS

Practice Transformation Committee

Support practice transformation through conferences; convene best practice learning collaborative sessions; support practice-based coaching and technical assistance; and support workforce development for PCMH. Tasked with deploying resources to practices for items such as practice coaching, NCM training and NCQA application assistance. Serve as liaison to other committees and external organizations.
Chairs: Andrea Galgay, MBA; Joanna Brown, MD, MPH

Program Evaluation Committee

Develop and oversee program evaluation activities.
Chairs: Jay Buechner, PhD; Bill McQuade, D.Sc., MPH; Brad Crough, MBA

South County Patient Centered Medical Community Steering Committee

Members include representation from the CTC primary care practices; NCMs; and Community Health Team and SC Hospital. The purpose is to share best practices and lessons learned, improve continued collaboration between the hospital and community based providers; and share data on performance to drive achievement of the triple aim.
Chair: Russ Corcoran, MD

Thank you to all who helped make 2014 a successful year!

Members of 2014 CTC Committees and Workgroups

- Provider Best Practices Workgroup Sharing Collaborative
- Community Health Team Planning Committee
- CTC Contracting Committee
- CTC Steering Committee
- Data & Evaluation Committee
- Integrated Behavioral Health Workgroup
- Large Learning Collaborative Planning Committee
- Nurse Care Manager Best Practice Sharing
- PCMH-Kids Stakeholder
- Practice Reporting Committee
- Practice Transformation Committee
- Program Evaluation Committee
- South County Hospital Patient-Centered Medical Home Community Steering Committee

State of Rhode Island

- Office of the Health Insurance Commissioner
- Executive Office of Health and Human Services
- Department of Health
- Office of the Lieutenant Governor

Payers

- Blue Cross and Blue Shield of Rhode Island
- UnitedHealthcare
- Neighborhood Health Plan of Rhode Island
- Tufts Health Plan
- Medicaid
- Medicare

Purchasers

- Lifespan Corporation
- Care New England
- State Employees Health Benefits Program
- Rhode Island Business Group on Health

Providers

- All participating CTC practice sites and members of their care teams and staff

Research and Technical

- Healthcentric Advisors
- Rhode Island Quality Institute

Partners and Supporters

- Rhode Island Foundation
- Brown University Practice Facilitators
- Blue Cross and Blue Shield of Rhode Island Practice Facilitators
- Department of Family Medicine, MHRI/CNE and Brown University
- The RIGHA Foundation Fund at the Rhode Island Foundation
- New England States Consortium of Systems Organization

Grateful for The Rhode Island Foundation's Support

The Care Transformation Collaborative of Rhode Island has been fortunate to receive support on many levels from the Rhode Island Foundation. Under their strategic initiative focused on healthy lives, the Foundation has served as the Collaborative's fiscal agent, giving our organization the support needed to develop and manage our important contracts, space and resources to host valuable learning opportunities for our practices and partners, and funds to support some of our key programs to improve care.

Neil Steinberg, President and CEO, speaking at a 2014 CSI-RI event. Photo courtesy of The Rhode Island Foundation.

In 2014, our successful Learning Collaborative was made possible through Rhode Island Foundation funding, which attracted nearly 300 primary care team members. The event, which featured local and national experts, gave our care providers an opportunity to address challenges, share best practices and focus on the growing role care teams play in patient-centered primary care. The Foundation also helped to sponsor our 2014 Practice Orientation, which introduced our new 25 primary care practice sites to the core values of the patient-centered medical home and practice transformation, as well as CTC reporting requirements and incentives that help improve care quality, patient experience and decrease costs.

Further, to progress our work focused on strengthening population health through the development of Community Health Teams and integrating behavioral health with primary care, the Rhode Island Foundation awarded our participating practice sites, South County Hospital and Blackstone Valley Community Health Care, grants to fund behavioral health clinicians within the Community Health Team program.

The Care Transformation Collaborative of Rhode Island is grateful to the Rhode Island Foundation for their generous support and encouragement. We look forward to continuing to partner as we work to improve the delivery of health care in our state.

CARE
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One report cannot capture all the innovation, collaboration, growth and success of our Collaborative. To learn more or get involved, contact us.

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